

Imposed Death

Euthanasia and Assisted Suicide

What's the BIG DEAL?

Euthanasia literally translated from Greek means “good death.” Some who promote euthanasia call it “mercy killing.” Death by euthanasia is neither good nor merciful. Therefore, in this publication, the more accurate term, “imposed death,” is frequently substituted for “euthanasia” and “assisted suicide” (see “Definitions” p. 3).

You may ask: Why should I be concerned? Why do I need to read this publication? Because the whole human race has a stake in the answer to the question, “Should imposed death be permitted and regulated by law?” History teaches us that a society which does not respect and protect all human life will ultimately bring about its own destruction.

Allowing certain people to be killed because their lives are viewed as “not worth living” or “burdensome” has profound repercussions for all of us. Devaluing one human life devalues all human life. (See the true stories in our “Case in Point” features.)

This supplement examines imposed death from various angles, highlighting the experiences and

opinions of those most intimately affected by it. In order to make informed decisions, you need the unvarnished truth about this vitally important topic.

Advocates of euthanasia and assisted suicide use terms like “choice in dying” and “self-determination.” They promote the social and legal acceptance of the “right to die”—that is, the “right” for individuals to choose how, when, where and why to die, and to receive assistance in dying from others. Although the expression “right to die” is seductive, giving governments the right to authorize our “right to die” begins the progression from voluntary imposed death to involuntary imposed death. Who will decide for those who cannot make their own choices? At what point does a “right” become an expectation, even a duty?

Instead of pursuing a “right to die,” let us strive to create an environment, a culture of life, in which no person feels compelled to seek the “quick fix” of death and every person’s life is respected by society and protected by law.

ACKNOWLEDGMENTS

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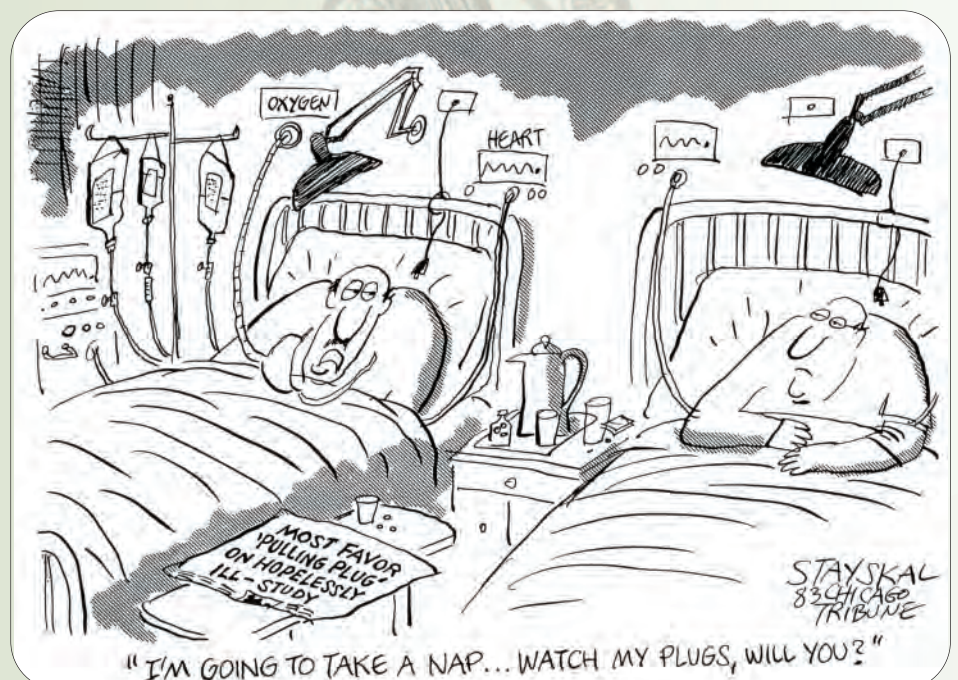
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Imposed Death in the U.S.

In the United States, while active euthanasia is still basically illegal, Living Will laws and court decisions have sanctioned euthanasia by omission. Assisted suicide is now considered legal in three states—Oregon, Washington and Montana. (To get a grip on terms used and groups named in this article, see “Definitions” below and “Progression,” p.4.)

Legalizing the “Right to Die”

In 1967, the educational branch of the Euthanasia Society of America (ESA) introduced the Living Will as a tool to “promote discussion of euthanasia.” Soon after, a campaign to pass laws making Living Wills legal documents was launched. In 1975, ESA changed its name to the Society for the Right to Die (SRD), improving its image by purging “euthanasia” (a reminder of the horrors of the German euthanasia program) from its name. The very next year, SRD tasted success: California enacted the world’s first Living Will law, the “Natural Death Act.”

Like dominoes, state after state fell for the claim that Living Will laws were necessary to give patients the right to refuse unwanted medical procedures, tubes and machines ahead of time in case they were ever incapacitated. In reality, Living Wills blurred the distinction between allowing a natural death and sending someone to an early grave. They were designed to be the first step toward gaining full blown acceptance of euthanasia and assisted suicide.

SRD involved itself in numerous “right to die” court cases which resulted in judicially sanctioned removal of feeding tubes (food and fluids) from severely brain-damaged patients. Choosing death by dehydration and starvation for disabled people, who could not speak for themselves, was hailed as somehow protecting their “right” to refuse unwanted treatment even if they had never expressed such a wish.

In 1991, SRD changed its name to Choice in Dying. The notion that death is a choice, that people should have the “right to die” on their own terms—or someone else’s terms—had become mainstream.

Next Step: Physician-Assisted Suicide

Derek Humphry, a British journalist, “assisted” his first wife, Jean, to kill herself by poisoning her morning coffee; then wrote a book about it called *Jean’s Way: A Love Story*. Humphry and his second wife, Ann Wickett Humphry, moved to America where they started the Hemlock Society (HS) in 1980. Appropriately named after the poison used by ancient Greeks for state-assisted suicide, the Hemlock Society’s purpose was to promote the unrestricted right to “self-deliverance.” HS argued that euthanasia and assisted suicide were not killing, but rather compassion, if the person wanted to die.

When Ann discovered that she had breast cancer, the same illness Jean had battled, Derek first encouraged her to end her life, then abandoned her. Sadly, her life did eventually end in suicide.¹ This series of events leads to a question: does promotion of “self-deliverance” have anything really to do with compassion?

HS-sponsored “physician-aid-in-dying” initiatives were rejected by voters in Washington in 1991 and California in 1992. The initiatives would have permitted both lethal injections and assisted suicide for patients diagnosed as terminally ill. Proponents attributed their defeat to the public’s

aversion to doctors killing patients and to opponents’ ads depicting a syringe-wielding physician. Learning by trial and error, they limited their next proposal—the “Death With Dignity Act”—to physician-assisted suicide (PAS) and succeeded in gathering enough signatures to get it on the Oregon ballot in 1994.

PAS supporters portrayed themselves as compassionate people who just wanted the legal right to gently end unbearable, untreatable pain. This was a stretch. The Act, in fact, did not mention pain at all. The only prerequisite for granting a request for PAS was the diagnosis (or misdiagnosis) of an illness expected to lead to death within six months.

Oregon voters narrowly (51%) approved the “Death With Dignity Act.” Held up by legal challenges, it finally went into effect in 1997. Jubilant PAS activists expected other states to quickly follow Oregon’s lead, but that did not happen. Since 1994, close to 90 assisted suicide measures have failed. In state after state they’ve encountered determined grassroots opponents—the disabled and elderly, poor people and ethnic minorities, church-goers and non-believers, doctors and nurses, etc. Their fundamental objections:

- ♦ A person whose life is seen by others as “not worth living” or “not worth the cost” of treatment may be given no other option than PAS.
- ♦ The act’s “safeguards” (e.g., the request for PAS must be voluntary, not coerced) may appear protective, but there are no provisions for enforcing them.
- ♦ A plea for assistance to kill oneself is a cry for help, not a choice to be honored.
- ♦ It’s simply wrong to use physicians and pharmacists to help people kill themselves.

Oregon stood alone as the only state where a doctor could legally prescribe a lethal dose of drugs for a patient to commit suicide – until 2008.

Washington and Montana

On November 4, 2008, Washington became the second state to legalize PAS. 59% of voters approved Initiative 1000, modeled after Oregon’s law. The new law is to take effect in July 2009.

It is heartening to report that the Washington State Medical Association is outspoken in its opposition to PAS. Also Eastern Washington’s largest hospital system, Providence Health and Services, will forbid physicians from helping patients die at any of its facilities.² Compassion & Choices (C&C) and Death With Dignity National Center (DDNC), the groups that led the I-1000 campaign, refuse to use the “s” word (suicide). They reject the term “physician-assisted suicide” and instead urge the use of more appealing terms like “death with dignity” and “aid-in-dying.” However, Washington’s medical providers aren’t stupid. Self-killing, even with a doctor’s help, is suicide. Legalization of assisted suicide does not turn a crime into a nice medical treatment.

A month after Washington voters legalized PAS, a Montana court followed suit. “The Montana constitutional rights of individual privacy and human dignity, taken together, encompass the right of a competent terminally [ill] patient to die with dignity,” wrote Judge Dorothy McCarter in the opinion for Montana’s First District Judicial Court. Compassion & Choices legal counsel presented arguments in the case brought by a retired truck driver suffering from leukemia and four physicians seeking legal sanction

for PAS. The case is likely to be appealed.

What’s Next?

In his 1991 book, *Final Exit* (a how-to commit suicide manual), Derek Humphry predicted, “When we have statutes on the books permitting lawful physician aid-in-dying for the terminally ill, I believe that along with this reform there will come a more tolerant attitude to the other exceptional cases.” C&C and DDNC are banking on that. They see legalization of PAS as the second step (legalizing Living Wills was the first) towards sanctioning imposed death.

¹ Marker, Rita. *Deadly Compassion*. 1993. | ² Stucke, John. “Medical providers say they won’t assist with suicides.” *SpokesmanReview.com*. 11/6/08.

Information

International Task Force on Euthanasia and Assisted Suicide
www.internationaltaskforce.org
800-958-5678

History Timeline of Imposed Death
www.humanlife.org/timeline.php

Definitions

Euthanasia means an act or omission which intentionally ends the life of an incurably ill, disabled or elderly person so that suffering and other difficulties may be eliminated.

- ♦ An act such as a lethal injection, smothering or shooting.
- ♦ An omission such as withholding or withdrawal of medical treatment and/or care (including food and water) that is life-preserving, beneficial (i.e., comforts or cures) and not unduly burdensome to the patient.

Involuntary Euthanasia is euthanasia without the person’s consent. This is gross patient abuse.

Voluntary Euthanasia is euthanasia with the person’s consent and is a form of suicide—self-killing. For instance, the voluntary stopping of eating and drinking by a person who is not in the throes of the dying process is suicide. And, if a physician prescribes drugs to keep the person highly sedated while he/she starves and dehydrates to death, this is a form of assisted suicide.

Assisted Suicide is self-killing with the assistance of another—e.g., a physician, friend or relative, or an organization that promotes assisted suicide such as Compassion & Choices or Final Exit Network, both national groups. The means—drugs, gun, plastic bag, how-to instructions, counseling, etc.—may be provided by someone else, but the last act is done by the person being killed.

Imposed Death is the more accurate term for ending the lives of human beings in order to end their suffering or to relieve others of the duty to care for them.

Note: It is not imposed death (euthanasia, suicide or assisted suicide) when a person refuses a potentially beneficial treatment because he/she deeply fears it or perceives it to be overly burdensome. That is a patient’s right. There is a world of difference between “allow her to die” and “kill her off.”

The Progression of Death Rhetoric

1938

The **Euthanasia Society of America** (ESA) was founded to promote legalization of euthanasia, both voluntary and involuntary.

1967

ESA established the **Euthanasia Educational Council** (EEC) which introduced the Living Will, a tool to gain acceptance of euthanasia.

1975

ESA changed its name to the **Society for the Right to Die** (SRD).

1979

EEC changed its name to **Concern for Dying** (CFD) and split from SRD.

1980

The **Hemlock Society** (HS) was formed to promote death-on-demand.

1991

SRD and CFD—having remerged in 1990—became **Choice in Dying**.

1993

Compassion in Dying (CID), an HS spin-off, was created to provide information and assistance to sick people who want to die and to promote “aid-in-dying” laws.

1994

The **Death with Dignity National Center** (DDNC) was established in Washington D.C. to work to replicate the new voter-approved Oregon “physician-assisted suicide” (PAS) law in other states.

1997

Last Acts, a coalition of more than 100 prominent organizations, funded by the Robert Wood Johnson Foundation, was established purportedly to improve the quality of end-of-life care. (“Improving care” is often code for hastening death.)

1999

Choice in Dying became **Partnership for Caring** (PFC). PFC managed the Last Acts program.

2003

HS started **End of Life Choices**, a political action committee, in Denver.

2003

The **Oregon Death with Dignity Legal Defense and Education Center**, the HS spin-off that originally drafted the “Oregon Death With Dignity Act,” became part of DDNC, which now describes itself as “the leader in this movement.”

2004

Final Exit Network was started by

disgruntled former HS and End of Life Choices members, including HS founder Derek Humphry. In 2007, the group was implicated in the suicide of a 58-year old Arizona woman with a history of mental illness. Network volunteer “guides” had assisted her “final exit.”

2004

PFC merged with Last Acts to form **Last Acts Partnership**, which folded soon thereafter. Some Last Acts members moved on to positions of influence in the realm of hospice and palliative care.

2005

Compassion in Dying and End of Life Choices joined to form **Compassion & Choices** (C&C) with headquarters in both Portland and Denver. C&C describes its program as “working to improve care and expand choice at the end of life,” but its actual efforts have been directed at only one “choice”—death. C&C, along with DDNC, has led campaigns to legalize PAS throughout the U.S. Since 1997, CID/C&C members have facilitated the majority of physician-assisted suicides in Oregon.

The Bottom Line

These groups all use nice-sounding words like rights, compassion, dignity

and choice, but every one of them came from the Euthanasia Society of America and the Hemlock Society—deadly names for deadly organizations. Their main agenda has been to take morally repulsive acts that end the lives of medically vulnerable human beings and make them into accepted medical practices. No matter how they try to sanitize it, **killing people when they are down is not dignified or compassionate.**

CaseinPoint!

An Oregon woman with early dementia died of assisted suicide. Her own physician refused to write the lethal prescription. A psychiatrist determined she was not eligible for assisted suicide because she was not explicitly pushing for it. Rather, her daughter seemed to be coaching her. The woman was then taken to a psychologist who determined she was competent but possibly under the influence of her “somewhat coercive” daughter. Finally, a managed care ethicist determined that she qualified for assisted suicide. *Editor’s Note: One major goal of managed care is to control the cost of health care services.*

(Source: *Oregonian*, 10/17/99.)



FOLLOW the MONEY



For some people in government and health care, limiting medical care and ending the lives of certain patients makes economic sense. One expert put it bluntly, “A quick death is a cheap death.”

“Futile care” used to mean that the patient would not benefit from treatment and, therefore, treatment was useless and should be stopped, a sound medical decision. Today, this term has an entirely different meaning. “Futile care” theory is the proposition that a physician is entitled to refuse to provide treatment, and even food and fluids, when he/she believes the quality of a patient’s life is too low or the cost is too high to justify further treatment. In other words, it’s the patient who is deemed useless, not the treatment.

Bioethicist Wesley J. Smith, in his book *Forced Exit*, suggests that money is “the most influential and dangerous force driving the euthanasia juggernaut.” In fact, advance directives (Living Will and Health Care Power of Attorney documents) work hand in hand with hospital “futile care” policies. Doctors

routinely go along with patients’ decisions to refuse treatment. However, when patients do not choose to forgo treatment, “futile care” policies allow that “choice” to be made by physicians and/or hospital ethics committees. Implicit in this “right to die” ethic is the frightening notion that some of us have a duty to die.

In 1987, Dr. Otis Bowen, Secretary of Health and Human Services (HHS), testified before the Senate Finance Committee that the way to attack high health care costs was to encourage Americans to sign Living Wills. In due course, the federal Patient Self-Determination Act (attached not to a health bill, but to the 1990 budget bill) became law. It requires facilities and programs that receive Medicare and Medicaid funds to tell every adult patient about their “right” to refuse treatment—i.e., sign a Living Will.

In 2005, HHS Secretary Mike Leavitt told hospital administrators that encouraging new Medicare participants to write Living Wills “would not just save families anguish but would likely save the system a remarkable amount of money...” High sounding goals such as “saving families anguish,” “doing what is best for patients” and “improving care” often camouflage cost-containment strategies.

One way to spot potential problems is to review a hospital’s or nursing home’s policy on withdrawal or withholding of tube-feeding. If a patient is not in the throes of the dying process, permanently withholding food and water will cause his/her death.

Food and water is ordinary, basic care whether it is delivered on a tray or through a tube. Unfortunately, imposed death by dehydration and starvation is becoming commonplace. Simply put—it saves money.

CaseinPoint!

“I’m not ready to die...I’ve got things I’d still like to do.” This was 64-year-old Barbara Wagner’s reaction to a crushing letter from the Oregon Health Plan informing her that it would not cover a prescription to slow the growth of lung cancer. “It was horrible,” she said. The unsigned letter stated that the plan would not pay for Tarceva, an expensive chemotherapy drug, but instead would cover comfort care, including assisted suicide. William Toffler, M.D., National Director of Physicians for Compassionate Care Education Foundation, was disturbed: “People deserve relief of their suffering, not giving them an overdose.” He also noted that the state has a financial incentive to offer death instead of life—drugs for assisted suicide cost less than \$100.

(Sources: *ABC News Internet Ventures*, 8/6/08; Susan Harding and KATU Web Staff, 7/31/08, www.katu.com/news/26119539.html)



ARE YOU SURE...

You'd NEVER Want to be "Hooked Up to a Machine?"

Your life or the life of a loved one may depend on having correct information about the ventilator, commonly called a "respirator."

Respiration is a bodily function, not a machine's function. It can only occur when the body's respiratory and circulatory systems are intact and functioning. A ventilator is an aid to breathing. The ventilator machine supports the ventilation part of breathing—moving air into and out of the lungs. It does not and can not cause the other part of breathing—respiration. Thus, the machine should always be referred to by its accurate name, "ventilator."

Many people with disabilities use ventilators every day of their lives to assist their breathing. For them, a ventilator is a necessity of life which allows them not only to continue living, but to breathe easier and enjoy life to its fullest. The ventilator is also commonly and effectively used to save lives.

I had not given much thought to the indispensable role that a ventilator plays in the healing process until three real life incidents brought the truth home to me.

My 41-year-old nephew was suffering from shocked lung syndrome after being injured in an automobile accident. This is a condition in which the elasticity of the lungs is greatly curtailed, causing intense pain and severe shortness of breath. To give his body a chance to heal without fighting for breath, the doctors induced a comatose state and put him on a ventilator. He was on the ventilator for

more than three weeks. His life was hanging by a thread or, more literally, a machine. When he was finally taken off the ventilator, his body took over, eventually completing the healing process. Today he is back working at his heavy-duty construction job—thanks to the ventilator and endless prayers.

In the second incident, a dear friend sustained a head injury.

Because his traumatized body started to shut down following surgery to close the wound, he too was put into a medically induced coma and

hooked up to a ventilator. He was in critical condition. After five days, he was taken off the ventilator and his natural breathing functions took over. This friend, who at 80 doesn't believe in retirement, is back working full-time, none the worse for the wear.

Imagine the outcome had he signed a Living Will that stated he would never want to be put on a "respirator." If you have made a statement to this effect, either orally or in writing, I advise you to promptly and emphatically rescind it.

In the third incident, a friend had a cardiac

arrest. He was taken to the hospital by ambulance and subsequently pronounced "brain dead." The attending physicians wanted to disconnect life support, but his wife wouldn't hear of it until all of their children could get home to say their goodbyes. After 72 hours, the sorrowing children had bid their father farewell. When life support was disconnected, their father sat up in bed and started talking to the

family! He went home shortly thereafter and the family was able to enjoy his company for four more years before he was called home to his Maker.

WHAT IF his wife had given consent to stop life support before his body's own healing powers had a chance to take their course with the aid of the ventilator?

I am now an enthusiastic believer in the healing benefit of the ventilator. We must all do our part to dispel the mistaken assumption that use of a ventilator is an extraordinary or heroic measure used only to temporarily prolong life. Its role in protecting and preserving

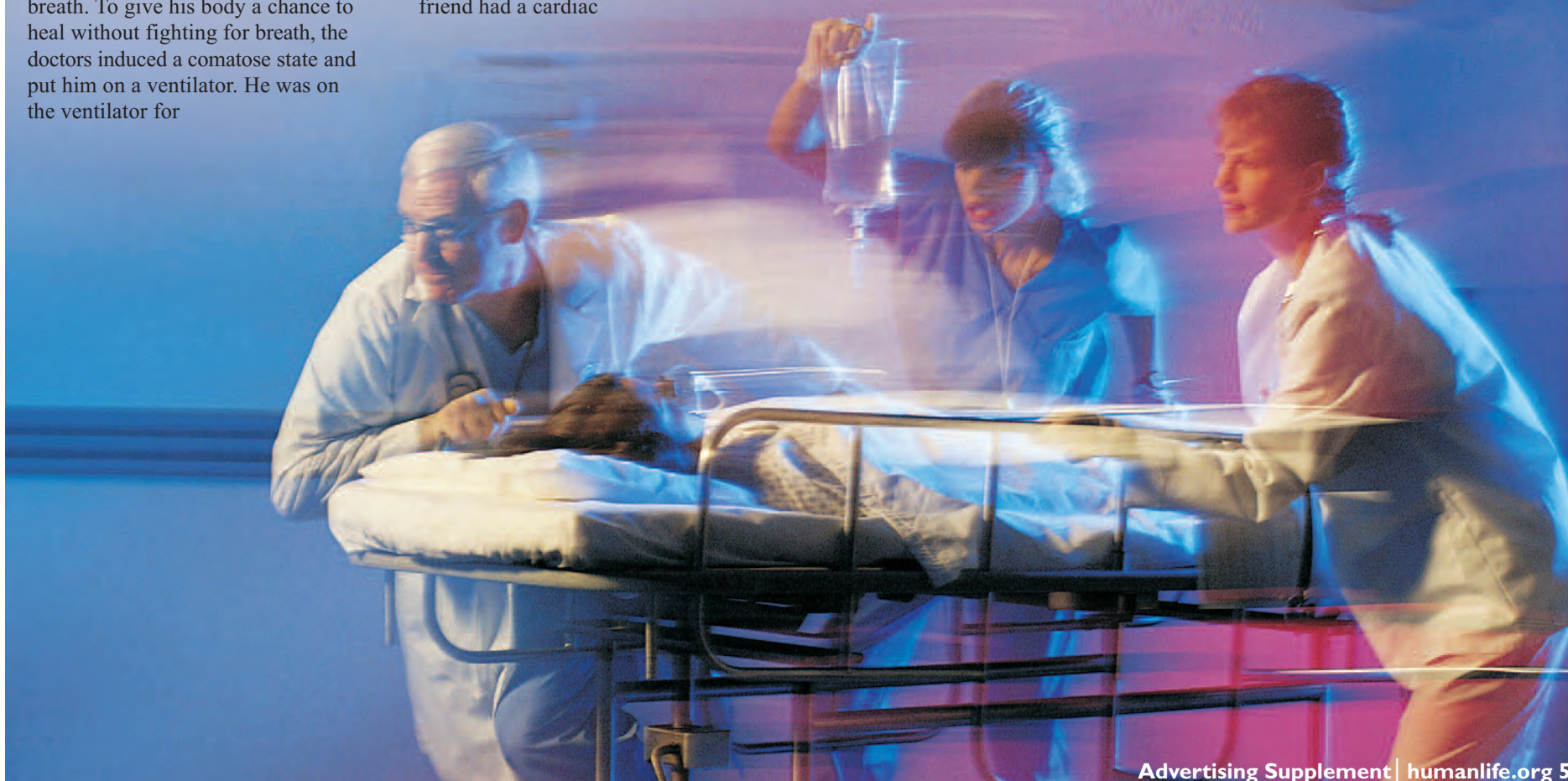
lives must be made more widely known. Providing accurate information about medical technology's benefits gives people the ability to make truly informed treatment decisions.

By Marlene Reid
President Emeritus
Human Life Alliance

Case in Point

Dr. Silvie Menard, head of the Experimental Oncology Department at the Institute of Cancer in Milan, was a supporter of euthanasia for many years. When she herself was diagnosed with bone cancer, "I changed my position radically," she told the Spanish magazine *Huellas*. "When you get sick, death ceases to be something virtual and becomes something that is with you every day," she said. "So you say to yourself: 'I am going to do everything possible to live as long as possible.'" (Source: *Catholic News Agency*, 4/11/08.)

Your life or the life of a loved one may depend on having correct information about the ventilator, commonly called a "respirator."



THIRSTY? TOO BAD.

Widespread legal and medical endorsement of death by dehydration and starvation has led to confusion. Is it right or wrong to withhold or withdraw food and water from seriously ill, physically or mentally disabled, or persistently unresponsive (so-called “vegetative”) patients?

It is important to distinguish between appropriate medical decisions and discriminatory decisions based on value judgments:

- ♦ When a person’s body is shutting down during the natural dying process, or when a person is unable to receive food and fluids without harm, it is appropriate to stop providing food and water. This is a medical judgment. In such a case, the patient dies naturally from his/her disease or injury.
- ♦ When a person is not dying (or not dying quickly enough), food and fluids, whether provided by mouth or tube, are sometimes withdrawn in order to cause death simply because the person is viewed as having an unacceptably low quality of life and/or imposing burdens on others. This is a value judgment. In such a case, the person is deliberately killed by dehydration and starvation.

Consider the cases of two elderly women. In 1984, 92-year-old Mary Hier had lived in a state hospital for over fifty years. Demented, but happy, she thought she was the Queen of England. Mary was not terminally ill, but had needed a feeding tube for many years. When her gastrostomy (stomach) tube became dislodged, a court denied permission to replace it, declaring that it would be “a major medical procedure” with “relatively high risk” due to her age. Just as Mary’s case was being reported, the same newspaper

carried another story about a 94-year-old woman who was doing well after “minor surgery to correct a nutritional problem.” The surgery, performed under local anesthesia on an outpatient basis, was the insertion of a gastrostomy tube. The woman was Rose Kennedy, matriarch of a rich and politically powerful family. Mary Hier’s life would have been prematurely ended without last minute intervention by a physician and an attorney who exposed the inequity. Her tube was replaced. Both women lived for a number of years longer.

In too many instances, whether inserting a feeding tube is considered a “major” or “minor” medical procedure depends upon whether the person is viewed by others as expendable or valuable, burdensome or beloved.

Advocates of euthanasia assert that providing food and fluids to patients is medical treatment that may be withheld or withdrawn. On the contrary, food and water are basic human needs and therefore basic human rights.

Feeding tubes are used for various reasons. Tube-feeding is often simpler, less costly and safer than spoon-feeding a patient who is a slow eater or chokes on food. It may be necessary for comfort, to ensure adequate nutrition and hydration, or to sustain life when a person is unable to swallow.

Real food and water are delivered through a feeding tube, though they are often inaccurately referred to as “artificial nutrition and hydration.” It is the feeding tube that is artificial, much as a baby bottle is an artificial means of delivering real nourishment to an infant who is not breastfed.

Dr. William Burke, a St. Louis neurologist, describes what happens to patients as they die an unnatural death

from dehydration:

They will go into seizures. Their skin cracks, their tongue cracks, their lips crack. They may have nose-bleeds because of the drying out of the mucus membranes, and heaving

“Imagine going one day without a glass of water! Death by dehydration takes 10 to 14 days. It is an extremely agonizing death.”

*and vomiting might ensue because of the drying out of the stomach lining. They feel the pangs of hunger and thirst. Imagine going one day without a glass of water! Death by dehydration takes 10 to 14 days. It is an extremely agonizing death.**

Food and fluids do not become “treatment” simply because they are taken by tube anymore than penicillin and Pepto-Bismol become “food” when taken by mouth. Those who claim otherwise do so to advance their own agenda. In 1984, at a World Federation of Right to Die Societies conference, bioethicist Dr. Helga Kuhse explained the strategy of euthanasia advocates:

If we can get people to accept the removal of all treatment and care, especially the removal of food and fluids, they will see what a painful way this is to die, and then, in the patient’s best interest, they will accept the lethal injection.

Deliberately causing a human being’s death by dehydration and starvation is inhuman. It is beneath the dignity of both patient and medical care provider. Nonetheless, in every state it is now

legal to impose death by taking away life-sustaining food and water. These laws are unjust and discriminatory. They imply that some people are “better off dead” and society is better off without them. They open the door to medical murder by lethal injection.

“Always to care, never to kill”

has been the constant motto of honorable medical professionals. No law can make killing patients, regardless of their perceived “quality of life,” medically or morally right.

* Smith, Wesley J. “Dehydration Nation.” *The Human Life Review*. Fall 2003. Vol. XXIX. No. 4. pp. 69-79.

Case in Point!

Lauren Richardson was 22 and pregnant when she overdosed on heroine. Diagnosed to be in a persistent vegetative state, she continued to receive medical treatment until her daughter’s birth. Lauren’s mother, Edith Towers, wanted to remove her feeding tube and was awarded guardianship when she testified that Lauren did not wish to be kept alive if there was no hope. Lauren’s father, Randy Richardson, appealed the ruling and took it public, which delayed the court order allowing removal of Lauren’s life support. Randy posted a question on Lauren’s website: “What are you going to tell Lauren’s daughter if she asks ‘Did you try everything before you gave up?’” That question hit Edith “real hard” and changed her mind. Lauren’s mother is thankful the legal process took long enough for her to reconsider her position. Lauren is now able to communicate and move all her limbs, and is trying to sit up on her own. Her father will be taking her home to continue her recovery. (Sources: *The News Journal*, 11/21/08, Lifefor lauren.org/updates.html)

Thanks for all the fish!

In 1990, 26-year-old Terri Schindler Schiavo suffered brain damage when she mysteriously collapsed and stopped breathing. Several years later, Michael Schiavo, her husband who was also her court-appointed guardian, sought judicial approval to remove her feeding tube and thereby end her life. Terri’s parents, Bob and Mary Schindler, along with her brother and sister, desperately struggled to save her life. The highly publicized tug of war between Michael and the Schindlers alerted millions to the fact that our judicial system has a history of sanctioning the treatment of disabled human beings in a way that would be criminal if done to a dog.

Contrary to inaccurate news reports, Terri was not on a ventilator, not terminally ill, and not “brain dead.” Physicians disagreed about whether or not she was in a persistent vegetative state. What we do

know is that she was a profoundly disabled human being totally dependent on others for her care. All her family wanted was to take her home and care for her, but that would not happen.

In March 2005, people from all over the country made their way to Florida to pray for and demonstrate their solidarity with Terri

Schiavo. They gathered outside the hospice where she was being dehydrated to death.

The media were mostly unsympathetic to these last friends of Terri and their expression of outrage that a court had seen her disability as reason to impose a death sentence.

John Zarella, covering the case for CNN, described their concern as “religious zealotry” and implied that they were “extremists” akin to criminals who murder abortion doctors.

Incredibly, on the same program, Zarella portrayed hundreds of people working to save two dozen dolphins as heroes. He reported, “The

volunteers are in the pool 24/7 holding the animals and keeping their blowholes out of the water so they can breathe. A veterinarian injects the dolphins with vitamin E to help with muscle cramping. These mammals are unable to eat on their own. Kate Banick uses a feeding tube to get them the nutrition they need.”

Not a word about zealotry or extremism.

It is a tragic irony that, in pre-World War II Germany (1933), strong animal protection laws were passed. Fifteen years later, the Nuremberg Tribunal declared the Nazi euthanasia program a “crime against humanity.” U.S. Brigadier General Taylor, chief counsel, concluded, “If the principles announced in this law had been followed for human beings as well, this indictment would never have been filed. It is perhaps the deepest shame of the defendants that it probably never occurred to them that human beings should be treated with at least equal humanity.”

The soul-searching question we must ask ourselves is: Are we at peace with deliberately dehydrating human beings to death, or does it haunt us?



“PERSISTENT VEGETATIVE STATE”

Human beings, even if seriously impaired in their higher brain functions, are not “vegetables.” The dehumanizing label “persistent vegetative state” (PVS) was crafted in 1972 just as the euthanasia movement began to pick up steam. It became more familiar in the 1980s as “right to die” activists, courts, state legislatures, physicians and bioethicists¹ began to use PVS diagnoses as justification for withdrawing food and fluids from severely brain-injured patients in order to make them die.

Many people have blind faith in medical labeling. Most probably think that PVS is a simple diagnosis. However, experts disagree about what it is and methods for diagnostic testing are disputed. PVS is grouped in the International Classification of Diseases with “Symptoms, Signs and Ill-Defined Conditions.”

A vegetative state is not a coma. According to the 1994 Multi-Society Task Force on the medical aspects of PVS (MSTF), a person in a coma is neither awake nor aware; a person in a vegetative state is awake but not aware.

The MSTF defined a “persistent vegetative state” as a vegetative state that lasts more than one month.²

The person in PVS has sleep-wake cycles, eye movement, and normal respiratory, circulatory and digestive functions. Individuals in PVS are seldom on any life-sustaining equipment other than a feeding tube. Some can swallow, others cannot. Some have random movement, some do not. Some have been physically injured. Others have had a stroke or have dementia. In some cases, the brain itself appears to change. In others it appears unchanged.

In simple terms, the diagnosis of PVS is based on lack of evidence of awareness of self and environment. However, it is not that simple.

Some patients who are misdiagnosed to be in PVS do exhibit evidence of awareness, but the diagnostician misses (or dismisses) the evidence. They may be mute and immobile (“locked-in”), but mentally alert and able to communicate by blinking or through aids such as computers, if someone gives them the opportunity. Other patients retain some measure of awareness even though they do not exhibit any evidence of it. Patients who have recovered from such a state can recall things that were said or done to them while no one knew they were aware.

The Washington Post, 9/8/2006, reported a case that astounded neurologists. A sophisticated brain scan, upon a woman supposedly in a vegetative state, indicated that she was clearly aware. The researchers told her to imagine she was playing tennis. They were shocked to see her brain “light up” exactly as an uninjured person’s would. They repeated the test again and again with the same result.

Misdiagnosis is Not Uncommon

- ♦ In 2002, a study of mistaken diagnoses of PVS revealed a 15% error rate.³
- ♦ Data gathered by the MSTF, on a group of 434 adult patients who were in PVS as a result of traumatic injury, showed that three months after injury, 33% had regained consciousness. By six months, 46% had and at 12 months, 52% had.⁴
- ♦ Out of 40 patients diagnosed as being in PVS, 17 (43%) were later found to be alert, aware, and often able to express a simple wish. The author, London neurologist Dr. Keith Andrews said, “It is disturbing to think that some patients who were aware had for several years been treated as being vegetative.”⁵

The *Times* of London recently reported that an unprecedented experiment, conducted with a special kind of scanner, by Cambridge neuroscientist Dr. Adrian Owen, showed that a woman had been wrongly diagnosed to be in PVS. “It revealed evidence of fluctuating levels of brain activation when she was

presented with pictures of her parents,” according to the report. “From that point, she started her long journey back into the world.” Scientists hope to develop functional brain tests which can be done at the patient’s bedside that won’t entail high cost or bulky machines. Using these tests to determine the extent of a brain injury may lead to better treatment and reduce the frequency of PVS misdiagnosis.⁶

The Unconscious World is Complex

Studies show that patients diagnosed to be in PVS feel pain. Indeed, a University of Michigan neurologist, in one of the most complete studies, concluded that when food and fluids are withdrawn [to impose death], the patient should be sedated.⁷

Some objections to deliberately ending the lives of patients in PVS have rested on the hope that “they might recover.” Let’s face it: many people with disabilities will not recover. Starving and dehydrating them to death is not a cure. It is cruel and inhuman.

It is now common for persistently unresponsive or minimally conscious patients who are not killed by dehydration to wind up warehoused in nursing homes, deprived of rehabilitation and beneficial medical treatment. The unconscious world is far more complex than most of us can imagine. Those who have severe brain damage may still enjoy touch, scent, taste, and sound. They may also feel loneliness, fear, and despair.

Their inability to satisfy our longing for response does not justify abandonment or imposed death.



Case in Point

A psychologist at Putney’s Royal Hospital for Neuro-disability told John Cornwell, a writer for the *Times* (London), this amusing story: “Young man with motorbike head injury in a coma. His mum, a keen evangelical, comes every day with friends to sing “Onward, Christian Soldiers” by his bedside. She’s hoping to stimulate his brain into action. It works: he comes round, but he can’t speak. So they fit him up with one of those Stephen Hawking-type laptops, and the first words he speaks are: ‘For God’s sake, Mum, shut it!’” Cornwell commented, “That’s about as funny as it gets on a brain-injury ward, but there’s a serious take-home message. Even minimally aware patients can retain emotions, personality, a capacity to suffer—and, as the young biker showed, attitude.” *Source: The Sunday Times*, 12/9/07

Narrow Escape: from a Planned Death

On September 11, 2005, 11-year-old Haleigh Poutre was admitted to Baystate Medical Center in Massachusetts. She was unconscious and clinging to life after allegedly being beaten by her adoptive mother and stepfather. Just eight days later, Haleigh’s doctors declared that she was “virtually brain dead” with no hope of recovery. This hasty diagnosis prompted the state Department of Social Services (DSS), which had custody of Haleigh, to seek permission for removal of her ventilator and feeding tube. A juvenile court judge granted the request.

Fortunately, DSS commissioner Harry Spence went to visit Haleigh before acting on the court order. To his surprise, he found her breathing on her own, conscious and able to respond to simple commands. Her planned death was called off and she was moved to a rehabilitation center where she continues to improve three years later. She is now writing her name, brushing her own hair, and feeding herself.

Sources: “Danger Zone.” Wesley J. Smith, National Review Online. February 1, 2006; <http://michellemalkin.com/2008/11/20/the-miracle-of-haleigh-poutre/>



¹Bioethicists are concerned with the ethical questions that arise in the interplay between life sciences, biotechnology, medicine, politics, law, philosophy and theology. | ²Mappes, Thomas A. “Persistent Vegetative State, Prospective Thinking and Advance Directives.” *Kennedy Institute of Ethics Journal*. 2003: Vol. 13. No. 2: 119-139 | ³Ibid. | ⁴Ibid. | ⁵*British Medical Journal*. 7/6/96. | ⁶Cornwell, John. “40% of coma patients in ‘vegetative state’ may be misdiagnosed, says a new report.” *The (London) Sunday Times*. 12/9/07. | ⁷*Detroit Free Press*. 6/26/90: 10A.

Hospice Care: The Good, the Bad and the Ugly

“Hospice care is there to make it possible for people who are dying to live fully until they die.”

— Dame Cecily Saunders

The purpose of hospice, as intended by its founder, Dame Cecily Saunders, is to provide comfort and supportive care for a person in the final phase of a terminal illness. Hospice forsakes all curative treatment for terminally ill patients, focusing on pain and symptom control. Employing a multidisciplinary team approach, it strives to meet the physical, social, psychological and spiritual needs of patients, their families and friends.

From Charity to Big Business

Hospice, in the 1970s, operated as a charitable service rendered primarily by volunteers. In the 1980s Medicare and Medicaid programs found it cost-effective to include hospice benefits. Since then the number of hospice programs in the United States has increased dramatically.¹ Unfortunately, as government and insurance (most HMOs provide hospice benefits) dollars rolled in, both fraud and cost-containment measures followed.

Euthanasia Advocates Like Hospice

Many of those who are involved in setting hospice and palliative care policies today have histories as key players in the movement to legalize euthanasia. (“Palliative” describes care that comforts and relieves pain.) In 2000, Choice in Dying (see “Progression” p.4), a long time promoter of euthanasia, merged with Partnership for Caring (PFC), an organization founded by Dr. Ira Byock, past president of the American Academy of Hospice and Palliative Medicine.² Dr. J. Donald Schumacher, a past vice chair for the now defunct PFC, is currently the president and CEO of the National Hospice and Palliative Care Organization (NHPCO), the largest organization of its kind.³ PFC was largely responsible for advancing the controversial practices of withholding food and water and terminal sedation, two principal avenues for death control and cost control.

Palliative Care Redefined

“Terminal sedation” (TS), sometimes called “palliative sedation,” means that a patient is given sedating drugs to render and keep him/her unconscious until death occurs. TS may be used because the patient is so near death that further treatment is useless and it is difficult to relieve the patient’s suffering with less extreme measures. However, this should rarely be necessary. Many experienced

palliative care nurses and doctors concur with the World Health Organization that pain can virtually always be controlled and, even in the most difficult situations, it is possible to adequately control a patient’s unpleasant symptoms without inducing a permanent comatose state.⁴

The real danger of TS is that it is a sneaky form of euthanasia or assisted suicide (see Definitions, p.3). Combined with the withdrawal of all food and water, it is used to deliberately end the lives of patients who are otherwise not dying or not dying quickly enough

damage are being placed in hospice in order to “help” them die.

Choosing a Good Hospice Program

Hospice patients receive care in their private homes, in hospital or nursing home units or in inpatient centers. Certified hospices are required to provide a basic level of care, but the quality and quantity of care vary significantly from hospice to hospice.

If hospice care is deemed appropriate and necessary, it will take time and effort to choose a good hospice. References from the patient’s primary

- continued for as long as the patient tolerates them
- ♦ make sure that temporary curable conditions, pneumonia for example, are properly treated
- ♦ insist that nutrition and hydration are continued, artificially-provided if necessary, until the patient is no longer able to assimilate them
- ♦ prevent the unwarranted use of terminal sedation.

The movement to incorporate euthanasia and assisted suicide into hospice is led by the few—unrepresentative of the many. There is no implication herein that hospice nurses and caregivers are consciously involved in deliberately hastening patients’ deaths. They deserve the utmost respect for their dedication in caring for the dying. However, to counteract and impede the encroachment of imposed death, the cooperation of hospice caregivers, patients, legal representatives, family members and friends is needed. They must be constantly on the lookout for policies and orders intended to cause or hasten death and be willing to oppose them.

As euthanasia and assisted suicide become more and more acceptable, those who have had good experiences caring for the dying need to tell their stories. They need to raise awareness of what is at risk when the duties to preserve life and to care for one another are deliberately abandoned and death is imposed.

“The often surprising potential for personal and family growth at this stage [end-of-life] is one of the strongest objections most hospice workers feel for the legalization of a deliberately hastened death. . .”

—Dame Cecily Saunders

**By Tracy Berntsen
Human Life Alliance**



to suit themselves or someone else. Dying from dehydration while under sedation can take up to two weeks. For this reason, TS is sometimes called “slow euthanasia.” TS is legal in every state, has been approved as ethical by the American Medical Association⁵ and is becoming routine in many hospices and palliative care programs.

Traditionally, hospice care was limited to patients who had been diagnosed with an incurable terminal disease. The requirement that two physicians must certify a patient has less than six months to live is still in effect today. However, an increasingly acceptable practice is the admission of non-terminally ill patients. Persons with disabilities, dementia and brain

physician, other trustworthy health care providers, friends or relatives who have had recent experience with the hospice being considered are invaluable. The hospice’s policies must be read thoroughly. It is unreasonable for a hospice to require a Do Not Resuscitate Order or an agreement stating that no tubes are to be put in the patient. Forced agreements should not be signed.⁶ While under hospice care the patient will need advocates to:

- ♦ check for unnecessary morphine dosages
- ♦ know the medications the patient is receiving and why
- ♦ make sure that medication and treatment for chronic conditions, other than the terminal illness, are

¹Dyer MD, Kristi A. “Hospice, Palliative and End of Life Care Statistics.” at http://dying.about.com/od/hospicecare/ss/hospice_stats.htm. Accessed 12/14/2008. | ²Dying Well. “Dr. Byock’s Biographical Information.” at www.dyingwell.org/byock.htm. Accessed 12/15/2008. | ³Center for the Advancement of Palliative Care. “Biography of J. Donald Schumacher, Psy D.” at www.cape.org/schumacher-bio/view?searchterm=Schumacher. Accessed 12/15/2008. | ⁴Chevlen, Eric M. and Wesley J. Smith. *Power Over Pain*. International Task Force on Euthanasia and Assisted Suicide. 2002. | ⁵O’Reilly, Kevin B., “AMA Meeting: AMA OKs Palliative Sedation for Terminally Ill.” at www.ama-assn.org/amednews/2008/07/07/prsi0707.htm. Accessed 12/15/2008. | ⁶Barra, Paul A. “Assisted Suicide on the Rise: States Poised to Pass Laws.” *National Catholic Register*. January 29-February 3, 2007.

Information

Hospice Patients Alliance
www.hospicepatients.org

LifeTree, Inc.
www.lifetree.org

What About PAIN Control?

MYTH: Terminally ill patients have to die in agonizing pain.

FACT: The World Health Organization assures us that even the most severe cancer pain can be eliminated or relieved.

Patients and their families need to insist that their physicians make every effort to control pain. If the doctor doesn't have the knowledge, time or compassion to treat pain effectively, find a new doctor. Some physicians have more expertise than others in the application of pain relief. One of the best ways to find a physician successful in treating pain is a personal referral from a trusted friend or relative.

Pain control is a central concern of hospice care. Federal guidelines regulating hospice care require the hospice to make

every reasonable effort to control a patient's pain. For varying reasons, some physicians may not order adequate medication for pain control. In these cases, hospice staff should intervene on behalf of the patient. It is a violation of patient's rights if physicians fail to provide needed medications or to seek advice on how to relieve patient's pain. Hospice medical directors are required by law to make sure the patient's needs are being met—including pain control.

Besides the myth that dying is always painful, there are many myths about medications such as:

- ♦ medications always cause heavy sedation
 - ♦ patients develop a tolerance to pain medications so it is best to save the strongest for last
 - ♦ some kinds of pain cannot be relieved.
- Recent advances assure that all pain can be

relieved by using a collaborative approach that incorporates a combination of therapies including chemotherapy, radiation, nerve blocks, physical therapies and psychosocial care.

Children with a terminal illness may be less likely to receive effective pain control because their parents and physicians don't want to "give up" on them. In their attempts to cure the child all the way to the end of life, adequate pain control may not be administered. Recognizing the child is dying is the first step in helping the child cope with their impending death and relieving their pain through adequate therapies.

An individualized pain control plan, developed collaboratively with members of the health care team, the patient, and the patient's family, will ensure pain control for the terminally ill.

Case in Point

Kevin Hines, a 19-year-old college student suffering from bipolar disorder, leapt from the Golden Gate Bridge in 2000. One of only 29 known survivors of the fall and with his illness now under control, Hines frequently lectures for a suicide-prevention network. He recently got married and is working toward a degree in psychology. "I'll tell you what I can't get out of my head," Hines told reporter Scott Anderson. "It's watching my hands come off that railing and thinking to myself, My God, what have I just done?" Suicide allows for no change of mind. *This is about death—not choice.* (Source: *The New York Times Magazine*, 8/6/08.)

What in the World is Going On?

Euthanasia and/or physician-assisted suicide (PAS) are now legal in four European countries. Activists in Europe and around the world are fighting for their decriminalization.

The Netherlands

In 2001, as a mere formality, the Netherlands legalized both euthanasia and PAS. Both practices had been widely tolerated since the early 1970s. Wesley J. Smith, attorney and bioethicist, neatly summarizes the progression of imposed death in the Netherlands:

First, Dutch euthanasia advocates said that patient killing will be limited to the competent, terminally ill who ask for it. Then, when doctors began euthanizing patients who clearly were not terminally ill, sweat not, they soothed: medicalized killing will be limited to competent people with incurable illnesses or disabilities. Then, when doctors began killing patients who were depressed but not physically ill, not to worry, they told us: only competent depressed people whose desire to commit suicide is "rational" will have their deaths facilitated. Then, when doctors began killing incompetent people, such as those with Alzheimer's, it's all under control, they crooned: non-voluntary killing will be limited to patients who would have asked for it if they were competent. And now they want to euthanize children.¹

Euthanasia's scope is ever-expanding. An inquiry commissioned by the Royal Dutch Medical Association concluded that doctors can euthanize patients who are "suffering through living" and ask for help to die, even though they have no physical or mental illness. Henk Jochmesen, director of the Lindeboom Institute for Medical Ethics, called the report dangerous and warned it has the effect that "we as a society should say to people who feel their life has lost meaning: right, you had better go away."²

Belgium and Luxembourg

Belgium legalized euthanasia and PAS in 2002. Taking advantage of European Union rules allowing patients to seek medical

treatment in another member state if it is unavailable at home, some foreigners have come to Belgium to end their lives.³

In 2008, Luxembourg's parliament decriminalized medical killing on request, in spite of the fact that the medical profession there was broadly against the legislation. The sovereign, Grand Duke Henri, refused to sign the law, thereby blocking it from going into effect. The Prime Minister responded by saying the country would change its constitution to reduce the powers of the sovereign.⁴ Good for the Grand Duke for sticking to his principles! While the Prime Minister will be complicit in every death under the law, the Grand Duke's hands will be clean.

Switzerland Invites Suicide Tourists

Although euthanasia is banned in Switzerland, assisted suicide is legal and non-physicians can be involved. The Swiss organization Dignitas, staffed by volunteers, has been offering assisted suicide since 1998 and has developed a regular tourist trade. 91% of its clients have been foreigners.⁵

In 2007, the Swiss Federal Court, ruling on a complaint brought by a mentally ill man who was refused assisted suicide, declared, "The right of self determination" [here citing article 8 of the European Convention of Human Rights] "includes the right to decide on the way and the point in time of ending one's own life; providing the affected person is able to form his/her will freely and act thereafter."⁶ Alex Schadenburg, executive director of the Euthanasia Prevention Coalition, reacted, "The Swiss have now opened the door to a free-fall into the abyss of the culture of death." He warned that this free-fall will end in "an obligation to die for the weakest members of society."

How far do Holland, Belgium, Luxembourg, Switzerland, not to mention the United States, have to fall before we come to our senses? We are all in peril.

¹ Smith, Wesley J. "Now They Want to Euthanize Children," www.weeklystandard.com. 9/13/04. | ² Shelden, Tony. "Dutch euthanasia law should apply to patients 'suffering through living,' report says." *British Medical Journal*. 1/8/05. | ³ BBC News. 4/04/08. | ⁴ www.wesleyj.smith.com/blog/2008/12/Luxembourg-culture-of-death-will-not-be.html. | ⁵ Research from the University of Zurich and Zurich University of Applied Sciences. | ⁶ Dignitas bulletin. 2/1/07.

Not Dead Yet: Support to Live, Not to Die



By Alison Davis

Editor's Note: Now age 53, Alison Davis has outlived her doctors' prognosis of terminal illness by 20 years.

I have spina bifida, hydrocephalus, emphysema, osteoporosis, arthritis and kypho-scoliosis. I use a wheelchair full time. Due to the osteoporosis, my spine is slowly collapsing, trapping nerves in the process. This causes extreme spinal pain which even large doses of morphine cannot fully control. When the pain is at its worst I cannot think, speak or move. It can go on for hours. The prognosis is that it will continue to get worse.

Twenty years ago, due to several factors, I decided I wanted to die—a settled wish that lasted over ten years. I seriously attempted suicide several times and was saved only because friends found me in time and got me taken to the hospital, where I was resuscitated against my will. Then I was extremely angry that my life had been saved. Now I'm eternally grateful. I still have the same severe pain I had then. What has changed is my outlook on life. If "assisted dying" had been legal, I wouldn't be here now. I would have missed the best years of my life.

What I wish most for those who despair of life is that they could have the sort of support and the reasons for hope which turned my life around, bringing me from the brink of death to

an appreciation and enjoyment of life.

Sometimes it's said that those who request death are just exercising their "right to choose." The problem is that often they feel they really "have no choice" because support mechanisms are not in place. And, of course, they are not just "choosing" for themselves. To say that death is in the best interests of some suffering people is to make value judgments about all who are disabled or terminally ill and suggests that death is a legitimate way of dealing with suffering. We can do better for suffering people than killing them. Legalizing medical killing would weigh against the further development of social and palliative care services to help us to live.

Once it is established that it is acceptable to cause death as a way of "preventing suffering," no sick or disabled person will be safe. It is instructive that when a non-disabled person expresses a wish to die, every effort is made to save his or her life. We have government strategies against suicide and "suicide prevention teams" to try to save the lives of those who want to die. Yet, when sick or disabled people express the same wish, possibly for much the same reason as those who are not physically affected, they are often assumed to be "right to want to die" and "better off dead." What we really need is the same presumption in favor of life as is routinely given to the non-disabled, and the same help and support to live with dignity until we die naturally. *Further reading: www.notdeadyetuk.org/alisondavies.php*

Information

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Down on the Transplantations:

Doctors Admit the Obvious; You Can't Get a Live Organ from a Dead Body

In a remarkably candid article in the *New England Journal of Medicine (NEJM)*, a doctor and a bioethicist make the unnerving observation that vital organ “donors” may not actually be dead at the time their organs are taken from them. While this statement corroborates the view of many pro-life groups, scientists, and physicians, it is likely news to the general public.

In their article, published online on August 14, 2008, Dr. Robert D. Truog of Harvard Medical Center and Children's Hospital Boston, and Dr. Franklin G. Miller, a bioethicist at the National Institutes of Health in Bethesda, Maryland, note that organ donation has been guided from its inception by the “dead donor rule,” which “simply states that patients must be declared dead before the removal of any vital organs for transplantation.” The traditional criteria for determining death, they note, was “straightforward: patients were dead when they were cold, blue, and stiff.”

Death Newly Defined

The problem is that by the time vital organs are extracted from such donors, they are no longer usable for transplantation. So, in 1968, a committee at Harvard proposed a new definition of death based on so-called “brain death” criteria: a patient with “devastating neurologic injury” could be considered eligible for organ removal under the dead donor rule. “Brain death” criteria have been in use ever since.

But, Truog and Miller write, these criteria are problematic because patients whose injuries are entirely intracranial “look very much alive: they are warm and pink; they digest and metabolize food, excrete waste, undergo sexual maturation, and can even reproduce. . . . The arguments about why these patients should be considered dead have never been fully convincing.”

In recent years, another definition of death has been proposed for prospective organ donors: “cardiac death.” Under cardiac criteria, a patient can be declared dead on the basis of “irreversible cessation of cardiac function” if his heart stops beating for as little as two to five minutes.

The authors point out that this definition also has problems. The term “irreversible” is commonly understood to mean “impossible to reverse,” but a patient whose heart has stopped for up to five minutes can often be resuscitated. So in order to meet the criteria of “irreversible cessation of cardiac function,” the word “irreversible” has to be interpreted to mean “we won't try” to resuscitate rather than “we can't.” The dishonesty of this becomes apparent when a heart declared to have permanently lost all function while in the chest of its original owner functions very well when transplanted into the chest of another person.

With respect to both “brain death” and “cardiac death,” the authors candidly admit that the justification for removing vital organs from patients “cannot be that we are convinced they are really dead.” The dead

donor rule may be invoked, but it is not followed.

Organs from the Living

Many persons are alive today because they have received organ transplants under just these circumstances. Given the shortage of viable organs for transplant, the thought of watching even more patients die for lack of organs must be distressing for doctors motivated by a sincere desire to save lives. This may explain why many of them have subscribed to the “brain death” and “cardiac death” definitions despite their untenability.

The authors point out that many others see these definitions as having been “gerrymandered” to “conform with conditions that are most favorable for transplantation.” They preserve the appearance of the dead donor rule but undermine its substance. And this, say the authors, is likely to “undermine trust in

patients, but also to obtain them from patients who “have devastating, irreversible neurologic injuries that *do not meet* the technical requirements of brain death” (emphasis mine).

To those who object that it is unethical to remove vital organs from living patients because the procedure will cause their deaths, the authors counter that, where “brain death” and “cardiac death” criteria are currently being used, “such actions are already taking place on a routine basis.” In other words: we're already killing patients by removing their vital organs, so let's keep doing it but just make sure that we have their permission first.

Candor Insufficient

To be fair, the authors are talking only about patients who have “devastating, irreversible neurologic injuries” and are very near death. One can sympathize with the frustration of a doctor who realizes that a few extra minutes of waiting for one patient to be indisputably dead are all that stand between him and another patient's many years. But those few minutes encompass the momentous difference between waiting on a person's death and killing him.

The authors' “consent” approach may be more honest than “gerrymandering” the definition of death, but it is no less utilitarian. Both are devised to “conform with conditions that are most favorable for transplantation.” Both seek to get around the basic principle that it is wrong to remove a person's vital organs before he is dead.

By Anita Kuhn

This article is a shortened version of one that first appeared in the October 2008 issue of Touchstone: A Journal of Mere Christianity (www.touchstonemag.com). Anita Kuhn is managing editor of Touchstone.

“Ironically, a patient regarded as ‘dead’ (for transplantation or experimental purposes) is sometimes treated as alive. Suction and postural drainage are done to prevent pneumonia. The patient is turned to prevent bed sores. How can a dead person (cadaver) develop pneumonia or bed sores?” — Dr. Byrne, Neonatologist and Clinical Professor of Pediatrics at Medical University of Ohio

the transplantation enterprise” at a time when authorities are trying to encourage more people to become organ donors.

The reader may conclude that the only rightful course is to call for a more faithful adherence to the dead donor rule, even though it would mean not being able to save as many transplant-needing patients as before—at least not until other medical advances are made. The protection of vulnerable patients, the preservation of medicine's moral integrity, and the restoration of public trust require it. That is not the conclusion Truog and Miller reach. The problem, as they see it, lies with the *reliance* on the dead donor rule, not the *manipulation* of it, which has fostered “conceptual confusion about the ethical requirements of organ donation” and “compromised the goals of transplantation for donors and recipients alike.”

Killing with Consent

Their solution is to continue using “brain death” criteria for organ removal, but to obtain “valid informed consent” from patients or their surrogates ahead of time. Then, not only would it be possible to continue extracting organs from “brain dead”

Case in Point

Numerous reports about people who have recovered consciousness after firm diagnoses of “brain death” provide ample evidence that “brain death” is not true death. Ponder Zack Dunlap's case. In November of 2007, this 21-year-old Oklahoman flipped over on his 4-wheeler and sustained catastrophic brain injuries. Thirty-six hours later doctors declared him “brain dead.” Preparations to harvest his organs were halted when Zack's cousin, a nurse, scraped his foot with a pocket knife and Zack jerked his foot away. Zack recalls hearing the doctor pronounce him dead and being “mad inside” but unable to move. He is now not only talking, but walking. (Source: *NBC News, Dateline*, 3/23/08.)

The Ostrich Syndrome

The ostrich, when frightened, buries its head in the sand. This bird-brained tendency is the reason that a person unwilling to face unpleasant facts is referred to as an “ostrich.” Another ostrich defense mechanism is its fierce and powerful kick. In like manner, human “ostriches” become angry and defensive when they are disturbed, for instance, by someone trying to open their eyes to the crimes against humanity being perpetrated under their very noses.

Herein we address an issue many people, for various reasons, are squeamish about examining closely: **organ procurement and transplantation**. A lot of folks would be more comfortable if we would simply ignore the abuses of human rights that are rife in this medical field. But hiding, or hiding from, cold hard reality is foolish and dangerous.

Let's Not Pretend

Transplant surgery is among the most prestigious and lucrative of medical specialties, but it is totally dependent on a constant supply of transplantable organs. This requires organ donors. The supply would soon dry up if the general public were aware that vital organs are being taken from living people who are conveniently called “brain dead” (see “Down on the Transplantations,” p.10).

Therefore, special interest groups play a deadly game of “let’s pretend” that apparently unconscious people with signs of life, normal pulse, blood pressure, color and temperature, are dead.¹

Let’s not pretend. Let’s pull our heads out of the sand and take a look at the business of organ procurement and transplantation with eyes wide open. Organ donors don’t realize that “Give the Gift of Life” literally may mean volunteering to give their lives on the operating table.

Organ Procurement

The Uniform Anatomical Gift Act (UAGA) was revised in 2006. It significantly changes organ donation and procurement rules and infringes on patients’ rights. The majority of states have already enacted the revised UAGA into law and the rest will follow. Consequently, all Americans need to be informed about how they will be affected.

Most importantly, under the revised UAGA, you must explicitly *refuse* to be a vital organ donor (for instance, as part of your advance directive for health care) or you will be considered a “prospective donor.” This means that if you are determined to be “dead or near death” the hospital must notify an organ procurement organization (OPO). The OPO will send a team to determine if your vital organs are suitable for transplant purposes. The OPO will have full access to your medical records and will be able to conduct tests, even ones that may harm you. Also, medical interventions may be continued or started solely to “ensure the medical suitability” of your vital organs. Your privacy will be invaded and medical procedures that are not for your benefit will be done without the knowledge or permission of your family. Only after your organs are determined to be suitable will your family be asked to consent to organ donation.

It is appalling to think that organs for transplantation have become more important than the rights of the person to whom they belong!

A Deadly Test

A “brain death” diagnosis cannot be made without an **apnea test** to determine that the patient is unable to breathe without assistance. (“Apnea” means the absence of breathing.) This test, during which the ventilator is turned off for up to 10 minutes, can cause brain swelling to worsen or even cardiac arrest. It has no benefit for the comatose patient and is conducted without the knowledge or permission of family members.²

It is simply wrong to risk killing a patient who, given treatment and time, might otherwise survive and resume spontaneous breathing. Nevertheless, medical professionals in the transplant system refuse to publicly acknowledge the detrimental effects of the apnea test. They also reject obtaining informed consent because no accurately informed family member, who loves the patient, would authorize it.³

Organ Removal: Pretending It Doesn't Hurt

Some organ harvesting procedures are truly sinister. Here are two examples:

- ♦ Dead people don’t react to being cut into. So the transplant team creates the illusion that the “brain dead” donor is dead by administering a paralyzing drug to prevent him/her from squirming and grimacing when the first incision is made. Yet, even paralyzed, the donor’s pulse races and blood pressure shoots up.
- ♦ Genuine cadavers don’t feel pain. Nevertheless, “brain dead” donors are often also anesthetized when their organs are removed.

The Bottom Line

People, especially physicians, who criticize transplantation ethics and practices are very unpopular. Nevertheless, some brave doctors do voice their concerns. For instance, the *Journal of Law and Medicine* (Oct. 2008) published an article by Dr. James Tibballs, an Australian pediatric intensive care specialist, in which he contends that, contrary to popular belief, most organs are harvested while donors are still alive. “It could be troubling for the public,” he observes, “to realize that doctors looking for organ donors are also the ones formulating guidelines on how to declare death...” Bill Silvester, medical director of LifeGift, responds, “This could be very damaging to public confidence of brain death diagnosis, because a lot of people might say ‘we don’t believe in this any more’...”⁴

Silvester’s reaction sheds light on the reason that ethical problems and disputes tend to happen below the public’s radar while reassuring arguments in favor of organ donation are broadcast widely.

Informed consent is the ethical cornerstone of organ donation and transplantation. When the public is intentionally uninformed or worse, misinformed, informed consent is impossible and medical ethics have been corrupted.

¹ The sole focus here is donation of *vital* organs (also called vascularized organs—organs that require continuous circulation of blood to remain useful for purposes of transplantation) after a diagnosis of “brain death.” Other types of donation are beyond the scope of this article. | ² Byrne, M.D. Paul A. “Wanted Dead or Alive: Organ Donors.” *Pro-Life Wisconsin*. 2007. | ³ Ibid. | ⁴ Gilbert, Kathleen. “Melbourne Doctor: Most Donors Still Alive when Organs are Removed.” *LifeSiteNews.com*. 10/21/2008.

Case in Point

In Paris, a team of French transplant surgeons were preparing to remove the organs of a 45 year old heart attack victim, when the man suddenly began to breathe, his pupils became responsive and he reacted to pain. After the man had been initially declared dead, doctors continued to massage his heart for an hour and a half while they waited for his organs to be removed. After a few critical weeks, the man is now walking and talking. Emergency room staff interviewed after the incident report they knew of other situations where “a person who everyone was convinced was dead, survived after prolonged re-animation...” (Source: *Telegraph News*, 10/10/08.)



Living Wills: Vital... or Deadly?

Advance directives for health care are legal documents by which individuals express their wishes in case they are ever unable to make health care decisions for themselves. There are two types: the Living Will and the Durable Power of Attorney for Health Care (DPAHC). Some advance directives are a combination of the two.

The laws governing Living Will and DPAHC documents permit the withholding or withdrawal of ordinary treatment and care, including food and fluids, even when the omission will be the direct cause of death. Thus, these documents can be used to license euthanasia. The wrong kind of advance directive in the wrong hands can be a deadly combination.

Federal regulations require every health facility and program that receives Medicare and Medicaid funds to inform patients about advance directives. Many hospitals and nursing homes give patients a Living Will or DPAHC to sign at the time of admission, a time when most people are under stress and distracted by other paperwork and questions. This is not an ideal circumstance for considering a legal document with life and death consequences. It is wise to arrive with your own carefully prepared directive in hand.

When considering an advance directive, you will need to understand the significant differences between the two types.

A Living Will is downright dangerous. It gives an attending physician, very likely a stranger,

the power to make life and death decisions for you. A doctor may do a poor job of deciphering your wishes, particularly if he/she does not share your moral values. Furthermore, real end-of-life decisions often involve complicated medical and ethical questions that can't be answered in a Living Will.

Keeping an open mind to the future is essential. It is impossible to give or withhold consent to treatment based on guesswork about a future illness or injury, and without knowledge of potential future treatment options. Nevertheless, the directions you give in a Living Will, by law, must be followed. Therefore, you may tie the hands of a physician whose skills could restore you to health or save your life. The directions in a Living Will are either so vague as to be useless or so specific as to be hazardous.

A Durable Power of Attorney for Health Care document is a better option. In a DPAHC you specifically name a trusted family member or friend ("agent") to make decisions for you if you are unable, either temporarily or permanently, to do so for yourself. Your "agent" will endeavor to make decisions in accord with your personal values and wishes. Your "agent" will base medical decisions on knowledge of your actual condition and treatment options, not guesswork.

It is important to discuss your wishes with your "agent" on a continuing basis. Preferences tend to change over time. Particularly as health declines, patients often accept medical interventions they

previously thought they would never want. Many people are not comfortable talking about aging, illness, injury and death. However, as difficult as it may be to discuss these issues ahead of time, during a medical crisis it may be even more difficult or even impossible.

As with any legal document, the wording of a DPAHC is critically important. Also, it must comply with the laws in your state. That is why Human Life Alliance recommends the Protective Medical Decisions Document (PMDD)* formulated by the International Task Force on Euthanasia and Assisted Suicide. The PMDD gives your "agent" the authority to act on your behalf and take legal action, if necessary, to insure that your rights are protected. The PMDD clearly states that your "agent" does not have the authority to approve the direct and intentional ending of your life. This limitation not only protects you, but it also protects your "agent" from being subjected to pressure to authorize such actions.

A Durable Power of Attorney for Health Care is absolutely essential for anyone who is 18 years or older. To be certain that a person you trust will be making medical decisions for you if you become incapacitated by an injury or illness, you must have specifically named that person in a legal document.

Filling out a PMDD takes only a few minutes - a few minutes that may mean the difference between life and death.

Information

*To obtain a PMDD packet specific to your state, contact: International Task Force on Euthanasia and Assisted Suicide, P.O. Box 760, Steubenville, OH 43952; 800-958-5678. www.internationaltaskforce.org

Advance Directives: Who Needs Them? (6 pages), 2004, International Task Force on Euthanasia and Assisted Suicide.

Life, Life Support and Death: Principles, Guidelines, Policies and Procedures for Making Decisions to Protect and Preserve Life. 2nd Ed. 2005, American Life League, 540-659-4171.

Common Sense

question now was comfort. If, for example, fluid did slowly build up again but Mary was comfortable, it could be burdensome to aspirate the fluid. However, if Mary did develop severe breathing problems that could not be controlled by medication, they might want to consider another aspiration since the goal was to make Mary as comfortable as possible during the short time she had left. "Why, that's just common sense!" her daughter exclaimed. Exactly!!

Sometimes, because it is assumed that a person is dying, other possibilities are overlooked. For example, when an elderly person doesn't feel well or eats very little, his doctor and family may think he is dying of old age and look no further. However, poor nutrition, depression, loneliness, and other reasons for the person's condition should be explored. The solution can be as simple as better nutrition, antidepressants, visitors or a pet. A thorough medical examination may

also reveal treatable physical problems. If the person is truly dying, he or she will die with or without interventions. But it is gratifying for all concerned when an elderly person makes a remarkable recovery after his or her true needs are identified and met.

If a time comes when it is impossible to heal or cure, we do not deliberately hasten death. We do what we can to meet the physical, emotional, social and spiritual needs of those who are seriously ill. We lovingly care for them until they die naturally.

Patients who want potentially effective treatment should not be denied it even when there is faint hope of curing or extending life. Extraordinary or experimental treatments can be tried with the option of stopping them if they don't produce the hoped for results.

A balanced view rejects imposed death while it accepts the ethically sound decision to stop medical interventions that are ineffective, harmful, extremely burdensome to the patient or overly zealous. It's just common sense.

¹ Valko, Nancy. "Whatever Happened to Common Sense at the End of Life?" 2007. www.lifeissues.net/writers/val/val_31commonsense.html.

It is virtually impossible to escape all the death talk in the media with its focus on worst case medical scenarios and perplexing treatment options. In spite of all the hype that leads people to feel overwhelmed or frightened by medical decision-making when they or their loved ones are seriously ill or injured, not every such situation involves wrestling with difficult dilemmas. Plain old common sense, along with accurate information, may be all that is needed to make a person's last stage of life as good as possible.

For instance, Nancy Valko, an intensive care nurse, recalls:

I once cared for Mary (not her real name), an older woman who was near death with cancer. Her loving family took her to the doctor when she became confused and severely short of breath. An x-ray showed a fluid build-up near her lungs. The doctor inserted a long needle, aspirated the fluid and Mary immediately improved. Still worried, the family asked me what they should do if the fluid built up again because they were afraid that this would prolong her death. I told them that the primary